Tennessee Department of Children's Services

FOSTER HOME/ GROUP HOME PRESCRIPTION MEDICATION RECORD

Child's Name _____**Month/Year**_____

Prescription Medication(s) [including Psychotropics]: (if more space is needed, use back of form)

Name: _____ Dosage: _____How Often Given: _____
Name: _____ Dosage: _____How Often Given: _____
Name: _____ Dosage: _____How Often Given: _____
Name: _____ Dosage: _____How Often Given: _____
Name: _____ Dosage: _____How Often Given: _____

Prescribing Provider's Name and Phone Number:_____
_____

Any Side Effects Noted: _____
_____

Any Changes or Improvements Observed: _____
_____

Missed Doses or Refused Doses: (if more space is needed, use back of form)

Date/Time: _____ Medication: _____ Reason:_____
Date/Time: _____ Medication: _____ Reason:_____
Date/Time: _____ Medication: _____ Reason:_____
Date/Time: _____ Medication: _____ Reason:_____
Date/Time: _____ Medication: _____ Reason:_____
Date/Time: _____ Medication: _____ Reason:_____
Date/Time: _____ Medication: _____ Reason:_____
Date/Time: _____ Medication: _____ Reason:_____
Date/Time: _____ Medication: _____ Reason:_____
Date/Time: _____ Medication: _____ Reason:_____

Weekly Prescription Medication Counts: (if more space is needed, use back of form)

Medication _____ Amt Remaining _____ Date _____
Medication _____ Amt Remaining _____ Date _____
Medication _____ Amt Remaining _____ Date _____
Medication _____ Amt Remaining _____ Date _____
Medication _____ Amt Remaining _____ Date _____
Medication _____ Amt Remaining _____ Date _____
Medication _____ Amt Remaining _____ Date _____
Medication _____ Amt Remaining _____ Date _____
Medication _____ Amt Remaining _____ Date _____
Medication _____ Amt Remaining _____ Date _____
Medication _____ Amt Remaining _____ Date _____

Next Appointment Date/ Time: _____

Number of Refills Remaining: _____